STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004550	A. BUILDING: _____ B. WING _____	R-C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL POND HEALTH CAMPUS	1014 MILL POND LN GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00195922 completed on March 29, 2016. Complaint IN00195922 - Corrected Date of survey: May 16, 2016 Facility number: 004550 Provider number: 155736 AIM number: 200526450 Census bed type: SNF: 21 SNF/NF: 35 Residential: 27 Total: 83 Census payor type: Medicare: 14 Medicaid: 31 Other: 11 Total: 56 Sample: 3 Mill Pond Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00195922. Quality review completed 5/17/2016 by 29479.	{R 000}		